

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

63-037487
STATE FILE NUMBER

9686

Registration District No.

Primary Registration District No.

Registrar's No.

DO NOT WRITE
ON THIS STUB

AMENDED

FILED OCT 4 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN Lemay.	
Length of stay in 1b 5 days		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis, Little Rock Hospitals, Inc.,		d. STREET ADDRESS (If outside, give location) 1405 Telegraph Road	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Russell Middle Wallace Last Dettmann		4. DATE OF DEATH Month Sept. Day 26, Year 1963	
5. SEX Male:	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1907
9. AGE (last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Simpson Express Co. St. Louis, Mo.	
11. BIRTHPLACE (City and state or country) U S A		12. CITIZEN OF WHAT COUNTRY U S A	
13a. FATHER'S NAME George Dettmann		13b. MOTHER'S MAIDEN NAME Anna Herzog	
14. NAME OF HUSBAND OR WIFE Bessie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Bessie Dettmann 1405 Telegraph Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA TO BRAIN DUE TO (b) PRIMARY CARCINOMA OF COLON DUE TO (c) 153.8		INTERVAL BETWEEN ONSET AND DEATH 6 Months 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 7:25 P.M., to Sept. 26, 1963 and last saw him alive on Sept. 26, 1963		Death occurred at 7:25 P.M., on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE J. H. Carner M.D.		22b. ADDRESS 1755 South Grand Blvd.,	
22c. DATE SIGNED 9-27-63		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 9-30-1963		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	
23d. LOCATION (City, town, or county) 1215 Lemay Ferry Rd. Lemay, Mo.		23e. DATE RECD. BY LOCAL REG. SEP 28 1963	
23f. REGISTRAR'S SIGNATURE Lois Smith, M.D.		23g. FUNERAL DIRECTOR Hoffmeister Mortuaries - 7814 So. Broadway St. Louis, Mo.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

VS 300
Rev. 4/59

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USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John L. Dennehy

Licensed Embalmer No. 4194

P. O. Address St. Louis, MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.